PEDIATRIC DENTISTRY

David L. Goldstein, D.M.D.

Release of Dental Information & Records

I_____authorize

David L. Goldstein D.M.D P.A. to furnish dental information and records concerning

_____
Patients Full Name

I release and hold harmless David L. Goldstein D.M.D., and the dentist's dental practice, members and employees, for liability, including for negligence that may arise from complying with this authorization.

I understand that the dental record maintained by David L. Goldstein D.M.D., P.A. may contain dental and administrative information from other healthcare providers. I also understand that the practice of David L. Goldstein D.M.D., P.A. is authorized by Florida law to charge me for duplicating x-rays for each child in a family.

This authorization shall remain in effect until revoked by me in writing. All prior authorization, if any, is hereby cancelled.

Reason for requesting dental information and records:

_____

_____

_____

There is a 48 hour waiting period for receiving dental records. At which time you may pick up dental records or have them mailed to the address of your choice.

If Mailed: _____
Name

_____
Street or P.O Box

_____
City State Zip

Signature _____**Print Signature**_____

Relationship to Patient:

_____**Date**_____

(Phone) 407-295-5437 **(Fax) 407-295-1280**